STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner
v **File No. 87989-001**

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 24th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 21, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act (PRIRA), MCL 550.1901, *et seq.* The Commissioner reviewed the request and accepted it on February 28, 2008.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on March 7, 2008.

The Petitioner's group health care coverage is defined by the BCBSM *Community Blue Group Benefits Certificate.* The issue in this external review can be decided by an analysis of this contract. The Commissioner reviews contractual issues pursuant to section 11(7) of the PRIRA, MCL 550.1911(7). This matter does not require a medical review by an independent review organization.

II
FACTUAL BACKGROUND

On November 17, 2006, the Petitioner participated as a driver in a tractor pull contest. He developed chest pain so he was rushed to XXXXX Hospital in XXXXX. Since XXXXX Hospital had no specialty services to treat the Petitioner, he was transported by air ambulance to XXXXX Hospital in XXXXX. The ambulance carrier, XXXXX, a non-participating provider, charged $12,525.00 for its services. BCBSM paid $5,164.88 leaving the Petitioner to pay the $7,360.12 balance.

The Petitioner appealed the amount BCBSM paid. BCBSM held a managerial-level conference on January 15, 2008, and issued a final adverse determination dated January 18, 2008. The Petitioner exhausted BCBSM's internal grievance process and seeks review by the Commissioner under PRIRA.

III
ISSUE

Is BCBSM required to pay more for the Petitioner's air ambulance services?

IV
ANALYSIS

Petitioner's Argument

The Petitioner says he passed out on the way to the first hospital and doesn't remember much about what happened. His wife asked about being sent to XXXXXor XXXXX but was told by the hospital that BCBSM only covered air ambulance to the nearest hospital able to treat him. Therefore, he believed that his air ambulance to XXXXX would be fully covered.

The physician who treated the Petitioner indicated his condition was too severe for Petitioner to be transported by ground ambulance. After he arrived at the hospital in XXXXX his heart was so weak he could not be operated on for three days. Therefore, Petitioner believes that his air ambulance transportation was medically necessary and should be a covered benefit. He had no choice what air ambulance company to use so he argues that BCBSM is required to pay the full

amount charged for this care.

BCBSM's Argument

BCBSM says it paid its approved amount for the Petitioner's air ambulance services. The certificate explains that if the Petitioner uses a provider that does not participate with BCBSM, he may be responsible for some or all of the balance of the charges. BCBSM says it is not obligated to pay more than the approved amount even in emergency situations or when the patient has no choice of providers.

The following table sets forth the amounts charged by the provider and the amounts paid by BCBSM:

Procedure Code	Amount Charged	Maximum Payment Amount	Amount Paid	Balance Due
A 0431	$7,300.00	$3,775.73	$3,775.73	$3,524.27
A 0436	$5,225.00	* $1,389.15	$1,389.15	$3,835.85
Total	$12,525.00	$5164.88	$5,164.88	$7,360.12

* BCBSM's maximum payment level per mile is $30.87.
The distance was 45 miles. Thus, $30.87 x 45 miles = $1,389.15.

Commissioner's Review

The certificate describes how benefits are paid. On page 5.4, the certificate says that BCBSM pays its "approved amount" for ambulance services. The approved amount is defined on page 7.2 as "the lower of the billed charge or [BCBSM's] maximum payment level for the covered service."

BCBSM's participating providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full. In Section 4 of the certificate, "How Physician and Other Professional Provider Services Are Paid," the Petitioner is cautioned about this (page 4.26):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

The certificate also requires the Petitioner to pay a deductible and copayment if nonpanel providers are used. In this case, the nonpanel deductible and copayment were waived because the services were provided on an emergency basis. Therefore, BCBSM paid its maximum approved amount for the Petitioner's air ambulance services.

It is unfortunate that the Petitioner had an emergency and was unable to use a participating air ambulance provider. Nevertheless, the certificate does not require BCBSM to pay more than its approved amount for services of a nonparticipating provider in such a situation, even if there was no choice of providers.

The Commissioner finds that BCBSM has paid the claim correctly according to the terms and conditions of the certificate and is not required to pay more for the services provided to the Petitioner.

V
ORDER

BCBSM's final adverse determination of January 18, 2008 is upheld. BCBSM is not required to pay more for the Petitioner's ambulance services provided on November 17, 2006.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.